(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2002. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2002, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2002. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

D. Notwithstanding Sections 1.020 and 17.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under item A, Section 11.051, items B and C, and item B of this Section. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

SECTION 11.060 **Total operating cost payment rate.** Through June 30, 1999, the nursing facility's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care-related payment rate determined in Section 11.020 and the adjusted other operating cost payment rate determined in Section 11.040.

SECTION ~~11.055~~ 11.070 **Salary adjustment per diem.** Effective July 1, 1998, ~~and ending June 30, 2001,~~ the Department shall make available the appropriate salary adjustment per diem calculated in item A through D to the total operating cost payment rate of each nursing facility subject to payment under this attachment, including Section 21.000. The salary adjustment per diem for each nursing facility must be determined as follows:

A. For each nursing facility that reports salaries for registered nurses, licensed practical nurses, and aides, orderlies and attendants separately, the Department shall determine the salary adjustment per diem by multiplying the total salaries, payroll taxes, and fringe benefits allowed in each operating cost category, except management fees and administrator and central office salaries and the related payroll taxes and fringe benefits, by 3.0 percent and then dividing the resulting amount by the nursing facility's actual resident days.

B. For each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the salary adjustment per diem is the weighted average salary adjustment per diem increase determined under item A.

C. A nursing facility may apply for the salary adjustment per diem calculated under items A and B. The application must be made to the Department and contain a plan by which the facility will distribute the salary adjustment to employees of the facility. In order to apply for a salary adjustment, a facility reimbursed pursuant to Section 21.000 must report the information required by items A or B in the application, in the manner specified by the Department. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after July 1, 1998, may constitute the plan for the salary distribution. The Department will review the plan to ensure that the salary adjustment per diem is used solely to increase the compensation of facility employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1998. If a facility's plan for salary distribution is effective for its employees after July 1, 1998, the salary adjustment cost per diem is effective the same date as its plan.

D. Additional costs incurred by facilities as a result of this salary adjustment are not allowable costs for purposes of the September 30, 1998 cost report.

SECTION 12.000 DETERMINATION OF INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES

SECTION 12.010 **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in Section 15.140, items A to C. The Department shall determine interim and settle-up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to Sections 12.020 and 12.030.

SECTION 12.020 **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to Sections 1.000 to 14.000, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in Section 13.000 to determine the anticipated standardized resident days for the reporting period.

B. The Department shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The Department shall use the anticipated resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in Section 10.010, must not be applied to the nursing facility's allowable historical per diems as provided in Sections 11.020 and 11.040.

E. The efficiency incentive in Section 11.040, items A or B, must not apply.

SECTION 12.030 **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to C.

A. The settle-up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle-up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in Section 9.020 must be used for the interim period.

(2) The Department shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The Department shall use the actual resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in Section 10.010 must not be applied to the nursing facility's allowable historical per diems.

(5) The efficiency incentive in Section 11.040, items A or B, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in Section 11.040, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine-month period in item C must be determined under Sections 6.000 to 14.090.

E. A newly-constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle-up total operating cost payment rate is determined under this subpart.

SECTION 13.000 RESIDENT CLASSES AND CLASS WEIGHTS.

SECTION 13.010 **Resident classes.** Each resident or applicant must be assessed according to items A to E based on the information on the assessment form completed in accordance with Sections 14.000 to 14.060 (Resident Assessment Section).

A. A resident or applicant must be assessed as dependent in an activity of daily living according to the following table:

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

B. A resident or applicant assessed as dependent in fewer than four of the ADLs in item A must be defined as Low ADL. A resident or applicant assessed as dependent in four through six of the ADLs in item A must be defined as Medium ADL. Each resident or applicant assessed as dependent in seven or eight of the ADLs in item A must be defined as High ADL.

C. A resident or applicant must be defined as special nursing if the resident or applicant meets the criteria in subitems (1) or (2):

(1) the resident or applicant is assessed to require tube feeding; or

(2) the resident or applicant is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:

(a) oxygen and respiratory therapy;

(b) ostomy/catheter care;

(c) wound or decubitus care;

(d) skin care;

(e) intravenous therapy;

(f) drainage tubes;

(g) blood transfusions;

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the categories in subitems (1) to (8) according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952);

(7) injury to nerve roots and spinal plexus (953); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is two or more for behavior on the assessment form.

SECTION 13.020 **Resident classes.** The Department shall establish resident classes according to items A to K.

A. A resident must be assigned to class A if the resident is assessed as:

(1) Low ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

B. A resident must be assigned to class B if the resident is assessed as:

(1) Low ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

C. A resident must be assigned to class C if the resident is assessed as:

(1) Low ADL; and

(2) defined special nursing.

D. A resident must be assigned to class D if the resident is assessed as:

(1) Medium ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

E. A resident must be assigned to class E if the resident is assessed as:

(1) Medium ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

F. A resident must be assigned to class F if the resident is assessed as:

(1) Medium ADL; and

(2) defined special nursing.

G. A resident must be assigned to class G if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) not defined special nursing; and

(4) not defined behavioral condition.

H. A resident must be assigned to class H if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) defined behavioral condition; and

(4) not defined special nursing.

I. A resident must be assigned to class I if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

J. Class J, 3.53;

K. Class K, 4.12.

SECTION 14.000 RESIDENT ASSESSMENT

SECTION 14.010 **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's case mix class. The assessment must be conducted according to the procedures in items A to ~~I.~~ J.

A. The county ~~preadmission screening~~ long-term care consultation team or hospital screening team under contract with the county must assess all nursing facility applicants for whom preadmission screening is required and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening, except as provided in subitems (1) and (2).

(1) The public health nurse of the county ~~preadmission screening~~ long-term care consultation team or the registered nurse case manager shall assess a nursing facility applicant, if the applicant was previously screened by the county ~~preadmission screening~~ long-term care consultation team and the applicant is receiving services under the alternative care grants program or under the Medical Assistance Program.

(2) An applicant whose admission to the nursing facility is for the purpose of receiving respite care services need not be reassessed more than once every six months for the purpose of computing resident days under Section 9.020, if the applicant has been classified by the Department of Health within the prior six-month period. In this case, the resident class established by the Department of Health within the prior six-month period may be the resident class of the applicant. A resident must not receive more than one assessment per respite care stay.

B. The long-term care consultation team will recommend a case mix classification for applicants and newly admitted residents when sufficient information is received to make that classification.

C. Except as provided in item A, subitem 2, the nursing facility must assess each applicant or newly admitted resident for whom a preadmission screening is not required or is not requested voluntarily. For the purposes of this item, the term newly admitted resident includes a resident who moves to a section of the nursing facility that is licensed differently than the section the resident previously was placed in or a resident who has been transferred

(3) not defined special nursing; and

(4) not defined neuromuscular condition.

J. A resident must be assigned to class J if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

(3) not defined special nursing; and

(4) defined neuromuscular condition or scoring three or four on behavior

K. A resident must be assigned to class K if the resident is assessed as:

(1) High ADL; and

(2) defined special nursing.

SECTION 13.030 **Class weights.** The Department will assign weights to each resident class according to items A to K.

A. Class A, 1.00;

B. Class B, 1.30;

C. Class C, 1.64;

D. Class D, 1.95;

E. Class E, 2.27;

F. Class F, 2.29;

G. Class G, 2.56;

H. Class H, 3.07;

I. Class I, 3.25;

from another nursing facility.

~~C.~~ D. Except as provided in item D, the assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing facility.

~~D.~~ E. Any resident who is required to be assessed by the ~~preadmission screening~~ long-term care consultation team under item A or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the ~~preadmission screening~~ long-term care consultation team within ten working days before or ten working days after the date the applicant is admitted to the nursing facility must be assessed by the nursing facility. The nursing facility must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

~~E.~~ F. Each assessment that the nursing facility is required to perform must be completed by a registered nurse. The registered nurse performing the assessment must sign the assessment form.

~~F.~~ G. The assessment of each applicant or newly admitted resident must be based on procedures of the Department of Health including physical observation of the applicant or newly admitted resident and review of available medical records, and must be recorded on the assessment form.

~~G.~~ H. Within five working days following the assessment, the ~~preadmission screening~~ long-term care consultation team or hospital screening team under contract with the county must send the completed assessment form to the Department of Health, and provide a copy to the nursing facility.

~~H.~~ I. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care must be submitted to the Department of Health by the nursing facility as a request for classification within ten working days after admission or after the assessment, whichever is later.

~~I.~~ J. The resident class for applicants or newly admitted residents must be effective on the date of the person's admission to the nursing facility.

SECTION 14.020 **Semiannual assessment by nursing facilities.** Semiannual assessments of residents by the nursing facility must be completed in accordance with items A to D.

A. A nursing facility must assess each of its residents no earlier than 162 days and no later than 182 days after the date of the most recent annual assessment by the Department of Health.

B. A registered nurse shall assess each resident according to procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse performing the assessment shall sign the assessment form.

C. Within five working days of the completion of the nursing facility's semiannual resident assessments, the nursing facility must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms, and the nursing facility's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing facility must provide additional information to the Department of Health if the Department of Health requests the information in order to determine a resident's classification.

D. Any change in resident class due to a semiannual assessment must be effective on the first day of the month following the date of the completion of the semiannual assessments.

SECTION 14.030 **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health will be effective as of the first day of the month following the date of completion of the Department of Health's assessments.

SECTION 14.040 **Assessment upon return to the nursing facility from a hospital.** Residents returning to a nursing facility after hospitalization must be assessed according to items A to D.

A. A nursing facility must assess any resident who has returned to the same nursing facility after a hospital admission. The assessment must occur no more than five working days after the resident returns to the same nursing facility.

B. In addition to the assessment required in item A, residents who have returned to the same nursing facility after hospital admission must be reassessed by the nursing facility no less than 30 days and no more than 35 days after return from the hospital unless the nursing facility's annual or semiannual reassessment occurs during the specified time period.

C. A registered nurse shall perform the assessment on each resident according to procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assessment, the nursing facility must forward to the Department of Health a request for a classification for any resident assessed upon return to the nursing facility after a hospital admission. This request must include the assessment form and the resident's medical plan of care. Upon request, the nursing facility must furnish the Department of Health with additional information needed to determine a resident's classification.

D. Any change in resident class due to an assessment provided under item A must be effective on the date the resident returns to the nursing facility from the hospital. Any change in resident class due to a reassessment provided under item B must be effective as of the first of the month following the assessment.

SECTION 14.050 **Change in resident class due to audits of assessments of nursing facility residents.** Any change in resident class due to a reclassification must be retroactive to the effective date of the assessment audited.

SECTION 14.060 **False information.** If the nursing facility knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the Department shall apply the penalties in Section 2.150.

SECTION 14.065 **Audit authority.** The Department of Health may audit assessments of nursing facility and boarding care home residents. These audits may be in addition to the assessments completed by the Department. The audits may be conducted at the facility, and the Department may conduct the audits on an unannounced basis.

SECTION 14.067 **Notice of resident reimbursement classification.** The Commissioner of Health shall notify each resident, and the nursing facility or boarding care home in which the resident resides, of the reimbursement classification established. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the Commissioner, and the opportunity to request a reconsideration of the classification. The notice must be sent by first-class mail. The notices may be sent to the resident's nursing facility. The notice must then be distributed within three working days after the facility receives the notice.

SECTION 14.070 **Request for reconsideration of classification.** The resident may request that the Commissioner reconsider the assigned reimbursement classification. The request must be submitted in writing within 30 days of the receipt of the notice. The documentation

accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

SECTION 14.075 **Facility's request for reconsideration.** In addition to the information in Section 14.070 a reconsideration request from a nursing facility must contain the following information: the date the notice was received by the facility; the date the notices were distributed to the resident; and a copy of the notice sent to the resident. This notice must tell the resident that a reconsideration of the classification is being requested, the reason for the request, that the resident's rate will change if the request is approved and the extent of the change, that copies of the facility's request and supporting documentation are available for review and that the resident also has the right to request a reconsideration. If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

SECTION 14.077 **Reconsideration.** The Commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the Department. If necessary for evaluating the reconsideration request, the Department may conduct on-site reviews. In its discretion, the Department may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request, the Department shall affirm or modify the original resident classification. The original classification must be modified if the Department determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing facility shall be notified within five working days after the decision is made. The Department's decision under this subdivision is the final administrative decision of the agency.

SECTION 14.080 **Change in resident class due to a request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration is pending.

B. Any change in a resident class due to a reclassification must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

SECTION 14.090 **Resident access to assessments and documentation.** The nursing facility must provide access to information regarding rates, assessments, and other documentation provided to the Department of Health in support of the resident's assessments to each nursing facility resident or the resident's authorized representative according to items A to D.

A. The nursing facility must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing facility. The nursing facility must include a notice that the nursing facility has chosen to appeal the rates.

B. The nursing facility must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the Department 30 days before the increase takes effect. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing facility must provide each nursing facility resident or the person responsible for payment with each classification letter received from the Department of Health within five days of the receipt of the classification letter. When the private paying resident is not the person responsible for payment, the classification letter must be sent to the person responsible for payment. If the resident's classification has changed, the nursing facility must include the current rate for the new classification with the classification letter.

D. Upon written request, the nursing facility must give the resident a copy of the assessment form and the other documentation that was given to the Department to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.

SECTION 15.000 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE

The appraised values determined under Sections 15.010 to 15.040 are not adjusted for sales or reorganizations of provider entities.

SECTION 15.010 **Initial appraised value.** For the rate year beginning July 1, 1985, and until August 31, 1992, the Department shall contract with a property appraisal firm which shall use the depreciated replacement cost method to determine the appraised value of each nursing

facility participating in the medical assistance program as of June 30, 1985. The initial appraised value of each nursing facility and any subsequent reappraisal under Sections 15.020 and 15.030 must be limited to the value of buildings, attached fixtures, and land improvements used by the nursing facility and must be subject to the limits in Section 15.040.

For hospital-attached nursing facilities, the Department shall require the appraisal of those portions of buildings, attached fixtures, and land improvements in service areas shared between the nursing facility and the hospital. The appraised value of the shared service areas must be allocated between the nursing facility and the hospital or other nonnursing facility areas using the Medicare worksheet B-1 statistics in effect on September 30, 1984. The appraised value of the shared service areas must be allocated by stepdown placing the appraised values on the appropriate line of column 1 on the Medicare worksheet B. The appraised value of the shared service areas allocated to the nursing facility shall be added to the appraised value of the nursing facility's buildings, attached fixtures, and land improvements.

For a newly-constructed nursing facility applying to participate in the medical assistance program which commenced construction after June 30, 1985 and until August 31, 1992, or a nursing facility with an increase in licensed beds of 50 percent or more, the Department shall require an initial appraisal upon completion of the construction. The construction is considered complete upon issuance of a certificate of occupancy or, if no certification of occupancy is required, when available for resident use. The property-related payment rate is effective on the earlier of either the first day a resident is admitted or on the date the nursing facility is certified for medical assistance.

SECTION 15.020 **Routine updating of appraised value.** For rate years beginning after June 30, 1986 and until July 1, 1992, the Department shall routinely update the appraised value according to items A to C.

A. The Department shall contract with a property appraisal firm which shall use the depreciated replacement cost method to perform reappraisals. Each calendar year, the Department shall select a random sample of not less than 15 percent of the total number of nursing facilities participating in the medical assistance program as of July 1, of that year. The sample must not include nursing facilities receiving an interim payment rate under Section 15.140. All nursing facilities in the sample must be reappraised during the last six months of the calendar year. Incomplete additions or replacements must not be included in the reappraisals. An incomplete addition or replacement is one for which a certificate of occupancy is not yet issued, or if a certificate of occupancy is not required, the addition or replacement is not available for use.

The updated appraised value for hospital-attached nursing facilities resulting from a reappraisal of shared service areas must be allocated to the nursing facility in the same ratio indicated by the Medicare stepdown in effect on September 30 of the rate year in which the reappraisal is conducted. The method described in Section 15.010, is to be used to determine allocation of the updated appraised value. The reappraised value of the shared service areas allocated to the nursing facility must be added to the reappraised value of the nursing facility's buildings, attached fixtures, and land improvements.

B. The Department shall compute the average percentage change in appraised values for the nursing facilities in the sample. The appraised value of each nursing facility not in the sample, and not reappraised under Section 15.030, must be increased or decreased by the average percentage change subject to the limits in Section 15.040. No redetermination of the average percentage change in appraised values shall be made as a result of changes in the appraised value of individual nursing facilities in the sample made after the Department's computation of the average percentage change.

C. For hospital-attached nursing facilities not in the sample, the allocation of the appraised value of the shared service areas must be recomputed if the hospital involved experiences a cumulative change in total patient days as defined by the Medicare program of more than 15 percent from the reporting year in which the most recently used set of allocation statistics were determined. The allocation using the method described in Section 15.010 must be based on the Medicare stepdown in effect on September 30 of the rate year in which the updating of the appraised value is performed.

D. The adjustment to the property-related payment rate which results from updating the appraised value is effective for the rate year immediately following the rate year in which the updating takes place except as provided in Section 15.140.

E. Each calendar year that a random sample is selected in item A to compute the average percentage change in appraised values in item B, the Department shall evaluate the adequacy of the sample size according to subitems (1) to (6).

(1) The tolerance level for an acceptable error rate must be plus or minus three percentage points.

(2) The confidence level for evaluating the sample size must be 95 percent.

(3) The sample size required to be within the tolerance level in subitem (1) must be computed using standard statistical methods for determination of a sample size.

(4) If the required sample size in subitem (3) is greater than the sample size used in item A, additional appraisals must be performed until the number of appraisals is equal to the required sample size in subitem (3). The additional nursing facilities needed to complete the required sample size must be randomly selected. A nursing facility that is receiving a special reappraisal under Section 15.030, or one that is receiving an interim payment rate under Section 15.140, or one that was appraised in the original sample in item A must be excluded. The average percentage change in appraised values in item B must be recomputed based on the increased sample size in subitem (3).

(5) If the tolerance level in subitem (1) continues to be exceeded after applying the procedures in subitems (3) and (4), the procedures in subitems (3) and (4) must be repeated until the error rate is within the tolerance level.

(6) If the required sample size in subitem (3) is equal to or less than the sample size used in item A, the average percentage change in appraised values must be the percentage determined in item B.

SECTION 15.030 **Special reappraisals.** Special reappraisals are subject to the requirements of items A to F.

A. A nursing facility which makes an addition to or replacement of buildings, attached fixtures, or land improvements may request the Department to conduct a reappraisal upon project completion. A special reappraisal request must be submitted to the Department within 60 days after the project's completion date to be considered eligible for a special reappraisal. If a project has multiple completion dates or involves multiple projects, only projects or parts of projects with completion dates within one year of the completion date associated with a special reappraisal request can be included for the purpose of establishing the nursing facility's eligibility for a special reappraisal. A facility which is eligible to request, has requested, or has received a special reappraisal during the calendar year must not be included in the random sample process used to determine the average percentage change in appraised value of nursing facilities in the sample.

Upon receipt of a written request, the Department shall conduct a reappraisal within 60 days provided that all conditions of this section are met. The total historical cost of the addition or replacement, exclusive of the proceeds from disposals of capital assets or applicable credits such as public grants and insurance proceeds, must exceed the lesser of $200,000 or ten percent of the most recent appraised value. The addition or replacement must be complete and a certificate of occupancy issued, or if a certificate of occupancy is not required, the addition or replacement must be available for use. Special reappraisals under this item are limited to one per 12-month period.

B. A nursing facility which retires buildings, attached fixtures, land improvements, or portions thereof without replacement, shall report the deletion to the Department within 30 days if the historical cost of the deletion exceeds $200,000. The Department shall conduct a reappraisal of the nursing facility to establish the new appraised value and adjust the property-related payment rate accordingly.

C. The adjusted property-related payment rate computed as a result of reappraisals in items A and B is effective on the first day of the month following the month in which the addition or replacement was completed or when the deletion occurred.

D. The Department shall reappraise every nursing facility at least once every seven calendar years following the initial appraisal. The Department shall reappraise a nursing facility if at the end of seven calendar years the nursing facility has not been reappraised at least once under Sections 15.020 or 15.030. The Department shall postpone the first seventh year catch-up reappraisals until the ninth year after the initial appraisal of all nursing facilities. The Department shall adjust the property-related payment rate to reflect the change in appraised value. The adjustment of the property-related payment rate is effective on the first day of the rate year immediately following the reappraisal.

E. The Department may require the reappraisal of a nursing facility within 60 days of receipt of information provided by the Minnesota Department of Health regarding the violation of standards and rules relating to the condition of capital assets.

F. Changes in the appraised value computed in this section must not be used to compute the average percentage change in Section 15.020, item B.

SECTION 15.035 **Appraisal sample stabilization.** The percent change in appraised values used for routine updating of appraised values shall be stabilized by eliminating from the sample of nursing facilities those appraisals that represent the five highest and the five lowest deviations from those nursing facilities previously established appraised values.

SECTION 15.040 **Determination of allowable appraised value.** A nursing facility's appraised value must be limited by items A to G.

A. The replacement cost new per bed limit for licensed beds in single bedrooms and multiple bedrooms is determined according to subitems (1) to (4):

(1) For the rate year beginning July 1,1992, the replacement-cost-new per bed limit must be $37,786 per licensed bed in multiple bedrooms and $56,635 per licensed bed in a single bedroom. After September 30, 1992, new projects which meet the requirements in Section 15.1374, item E, shall receive the replacement-cost-new per bed limits in that

provision.

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in Section 15.100, item A and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

(3) The differences computed in subitem (2) are the replacement cost new per bed limits for licensed beds in single bedrooms and multiple bedrooms effective for the rate year beginning on July 1, 1991.

(4) On each succeeding January 1, the Department will adjust the limit in subitem (1) and the depreciable equipment costs in subitem (2) by the percentage change in the composite index published by the Bureau of the Census Composite fixed-weighted price of the United States Department of Commerce in the C30 Report, Value of New Construction Put in Place for the two previous Octobers.

B. Each nursing facility's maximum allowable replacement cost new is determined annually according to subitems (1) to (3):

(1) The multiple bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in multiple bedrooms.

(2) The single bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in single bedrooms except as provided in Section 15.110, item C, subitem (2).

(3) The nursing facility's maximum allowable replacement cost new is the sum of subitems (1) and (2).

C. The nursing facility's replacement cost new determined in Sections 15.010 to 15.030 must be reduced by the replacement cost new of portions of the nursing facility used for functions whose costs are disallowed under Sections 1.000 to 18.050. Examples of such adjustments include non-nursing facility areas, or shared areas, therapy areas, day care areas, etc.

D. The adjusted replacement cost new is the lesser of item B or C.